Dear Prospective Certified Nursing Assistant Student:

We are pleased to welcome you to Alvin Community College and look forward to assisting you in starting your career goals in health care. As a certified nursing assistant, you will have many doors of opportunity open to you in the health care arena.

The CNA program is part of the Department of Continuing Education Workforce Development. Therefore, any correspondence with the campus must be labeled Dept. of CEWD to prevent your mail from being bogged down. A complete mailing address is below.

Please complete the packet of information and then you may come by Building H, room 103 on the Alvin Community College campus or call and register by credit card over the phone at 281-756-3787. The administrative assistant can answer most of your questions regarding the class or will gladly forward you to the Director of the CNA program. If you have any further questions on the program, you may contact me at 281-756-3581.

We wish you great success with the program and welcome you again!

Sincerely,
Bonnie Thibodaux
Director of Certified Nursing Assistant Program

Susan B. Priest, RN, MSN, CNS
Director of Health and Medical Programs

Alvin Community College
Dept of Continuing Education
3110 Mustang Road
Alvin, Texas 77511-4898

* MUST BE CPR CERTIFIED BEFORE START OF CLINICAL
* MUST BE ABLE TO READ, WRITE AND UNDERSTAND ENGLISH
* MUST SPEAK WITH PROGRAM DIRECTOR PRIOR TO REGISTRATION
Certified Nursing Assistant Student Application
Alvin Community College Continuing Education
APPLICATION FOR COURSE ADMISSION

NAME ____________________________

SOC SEC# ____________________________ DATE ____________________________

ADDRESS ____________________________ (Street) ____________________________ (State) ____________________________ (Zip Code) ____________________________

PHONE ( ) ____________________________ ALTERNATE PHONE ( ) ____________________________

EMERGENCY CONTACT ____________________________ (Name) ____________________________ (Relationship) ____________________________ (Phone #) ____________________________

CURRENTLY EMPLOYED: ____________________________

WORK HOURS/WEEK (OUTSIDE HOME) DURING COURSE? ____________________________

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ______ (IF YES, PLEASE CONTACT DIRECTOR OF CNA PROGRAM.)

EMAIL ADDRESS (OPTIONAL) ____________________________

I, ____________________________, HEREBY STATE THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

(Print Name) ____________________________

(Signature) ____________________________ (Date) ____________________________

STUDENTS WITH DISABILITIES
This college adheres to all applicable federal, state, and local laws, regulations, and guidelines with respect to providing reasonable accommodations as required affording equal educational opportunity. ACC provides reasonable accommodations for qualified individuals who are students with disabilities. It is the student’s responsibility to contact the Counseling Center in a timely manner to arrange for appropriate accommodations. Once the disability is identified, please notify your Instructor for additional modifications.
To provide a safer, more secure workplace, criminal history background checks are now an integral part of the employment procedure. In an effort to avoid negligent hiring incidents, background checks are conducted on all candidates recommended for regular, full time positions. Alvin Community College uses First Advantage Background Services, which provides background screening services on a local and national level for this element of the employment procedure.

I am an applicant for employment and/or current employee with ALVIN COMMUNITY COLLEGE, and have been advised that as a part of the application / employment process, the Employer conducts a criminal history background check. By submission of this form, I consent to the Employer, use of any information provided in the application process in performing the criminal history check. The Employer has informed me that I have the right to review and challenge any negative information that would adversely impact a decision to offer employment. In addition, I have been informed that I will have a reasonable opportunity to clear up any mistaken information reported within a reasonable time frame established within the sole discretion of the Employer. Under the Fair Credit Reporting Act (FCRA), I have been advised that upon request, I will be provided the name, address and telephone number of the reporting agency, as well as the nature, substance and source of all information.

Signature is not required; completion of the form will serve as authorization for the background check.

FORM: 10/10/08
PHYSICAL EXAM FORM

<table>
<thead>
<tr>
<th>Health Program</th>
<th>Certified Nursing Assistant</th>
</tr>
</thead>
</table>

Student Name: ____________________________

Date of Birth: _________________________

**NOTE:** While confidentiality of this information will be maintained, full health information is necessary for the student’s protection as well as that of others.

1. **Medical History:** (To be completed by Student)

Please identify any of the following for which you have received medical treatment within the past five years:

<table>
<thead>
<tr>
<th>Chronic illnesses</th>
<th>Menstrual disorders</th>
<th>Joint disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic fever</td>
<td>Epilepsy</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>Back injuries</td>
<td>Diabetes</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>Hay fever</td>
<td>Tuberculosis</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Frequent colds</td>
<td>Asthma</td>
<td>Ulcer/colicitis</td>
</tr>
<tr>
<td>Anemia</td>
<td>Frequent headache</td>
<td>Other (please describe)</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Please list (with dates if possible)
  1. **Chronic illnesses**
  2. **Current medications**
  3. **Physical limitations**
  4. **Currently pregnant** *

  *If yes, must provide Physician’s release*

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Primary Care Provider’s Name (Please Print)

Office Address (Street)

Telephone

City __________ State __________ Zip __________

I, ____________________________________________________________________________ HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE

INFORMATION IS TRUE AND FACTUAL.

Student signature ____________________________ date ____________________________
Certified Nursing Assistant Student Application
Alvin Community College Continuing Education
DECLINATION OF HEPATITIS VACCINE

I, ________________________________ have been duly notified of the hepatitis B requirements for healthcare providers, have been directed to resources for obtaining this vaccine, and choose to decline receiving this vaccine at this time.

Accept this as my official statement of declination of hepatitis vaccine series.

______________________________  __________________________
(Signature)                     (Date)
# IMMUNIZATION RECORD

<table>
<thead>
<tr>
<th>Health Program</th>
<th>Certified Nursing Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

**Tuberculosis Screening**: Skin test **OR** Chest x-ray (if skin test is positive). Must be within 12 months prior to start of course.

- **TB Test Date**: Date Read:
- **Chest x-ray date**: Results:

**Immunizations**: The Texas Dept. of Health requires the following immunizations for students enrolled in health related courses:

- **Measles, Mumps, and Rubella (German Measles)** (all students born after 1956)
  - 1 dose measles, mumps, AND Rubella vaccine administered on or after 1st birthday **OR** serologic confirmation of immunity

- **Tetanus/Diphtheria** (all students)
  - 1 dose T/D within past 10 years (mo/day/yr must be recorded)

- **Varicella** (Chicken Pox) (all students)
  - 2 doses of Varicella vaccine on or after 1st birthday **OR** immunity verified by student/parent/physician **OR** serologic confirmation of immunity

- **Hepatitis B** series of three immunizations **OR** serologic confirmation of immunity

<table>
<thead>
<tr>
<th>Date (mm/dd/yr)</th>
<th>Vaccine</th>
<th>Validation Signature/Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MMR (measles, mumps, rubella)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>T/D (Tetanus/Diphtheria)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B (3 doses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Varicella (Chickenpox) /Date of Disease</td>
<td>Must complete statement below</td>
</tr>
</tbody>
</table>

_I, ___________________________ hereby state that all information provided above is true and accurate to the best of my knowledge._

(Signature) (Date)
# CNA Registration Checklist

The following forms are required at the time of registration. There will be NO exceptions.

**TO BE COMPLETED BY CE OFFICE**

<table>
<thead>
<tr>
<th>REQUIRED DOCUMENTS</th>
<th>RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLICATION</td>
<td></td>
</tr>
<tr>
<td>PROOF OF CPR (OR ENROLLMENT THE CLASS)</td>
<td></td>
</tr>
<tr>
<td>TB SCREENING RESULTS</td>
<td></td>
</tr>
<tr>
<td>IMMUNIZATION RECORDS</td>
<td></td>
</tr>
<tr>
<td>DECLINATION OF HEPITITIS</td>
<td></td>
</tr>
<tr>
<td>BACKGROUND CHECK RECEIPT</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL AID APPROVAL (IF APPLICABLE)</td>
<td></td>
</tr>
</tbody>
</table>

RECEIVED BY:                                                     DATE: